STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155689	A. BUILDING _____ B. WING _____	C 03/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD HEALTHCARE CENTER	2400 COLLEGE AVE GOSHEN, IN 46526

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaint #IN00104159 and Complaint #IN00105828. Complaint #IN00104159 - Unsubstantiated due to lack of evidence. Complaint #IN00105828 - Unsubstantiated due to lack of evidence. Survey dates: March 26-27, 2012 Facility number: 000091 Provider number: 155689 AIM number: 100290080 Survey team: Honey Kuhn, RN, TC Carol Miller, RN Julie Wagoner, RN Census bed type: SNF: 33 SNF/NF: 117 Total: 150 Census payor type: Medicare: 24 Medicaid: 89 Other: 37 Total: 150 Sample: 7 Courtyard Healthcare Center was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the Investigation of Complaint #IN00104159 and Complaint #IN00105828.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD HEALTHCARE CENTER	**2400 COLLEGE AVE GOSHEN, IN 46526**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 Quality review 3/29/12 by Suzanne Williams, RN	F 000		